The rectum was divided 5 cm distal to the rectosigmoid junction through apparently normal bowel and a total colectomy with a Hartmann's procedure carried out. Histological examination confirmed the absence of ganglion cells and abnormal collections of unmedullated nerve trunks in the distal 35 mm of rectum, the rest of the colon being normal.

His immediate postoperative recovery was complicated by cardiorespiratory instability resulting from return of the mediastinum to its normal position. After 24 hours' ventilation, however, he made an uneventful and complete recovery. At review a year after surgery he remained extremely well. His comment on his ileostomy was "I don't know why I didn't have this done 50 years ago."

Comment

Hirschsprung described the condition of congenital megacolon in 1888,[3] but the true cause of the condition was obscure until Tittel described degenerate ganglion cells in the segment of bowel distal to the megacolon.[4] This enabled true aganglionosis to be distinguished from other causes of acquired megacolon. Although originally recognised in children, it was suggested that mild cases of Hirschsprung's disease might survive to adult life. Several adult series have been reported where elective surgery has been carried out for longstanding constipation.[2 4]

Many of the reported cases are in their second or third decade and it seems exceptional for patients to present over 50 years of age. Maglietta described a 69 year old woman with evidence of aganglionosis,[5] but the patient died before surgery could be performed.

The case we report here showed many of the features of adult Hirschsprung's disease, including stercoral perforation[6] and respiratory failure,[7] and is, we believe, the oldest case so far recorded. In cases of severe constipation Hirschsprung's disease should be considered irrespective of the patient's age and can be confirmed by elective full thickness rectal biopsy.

We thank Mr R M R Taylor for permission to report this case.

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For Debate . . .

Surgical oncology—40 years behind

R DAVID ROSIN

The James Ewing Society was founded in the United States in 1940 to further the knowledge of cancer. Its founder members were mostly surgeons from the Memorial Sloan Kettering Hospital in New York and they moulded the future for surgical oncology to become a recognised specialty. In the United Kingdom today, though we have had a British Association of Surgical Oncology for nearly a decade, surgical oncology is probably at the same stage now as it was at the time of James Ewing's death 40 years ago.

There are numerous reasons for the slow progress of surgical oncology as a recognised specialty. Traditionally, subspecialties in surgery have had difficulty becoming recognised, and some specialists are still having problems breaking away from the title "general surgeon with a special interest in. . . ." The overriding factor holding back surgical oncology in Britain is simply that there is not the same wealth poured into prevention, research, and treatment of cancer here as there is in the United States. The reticence of many general surgeons, however, not to accept the need for surgical oncologists and the lack of training programmes are also pertinent factors. Indeed, if one looks for academic posts one finds that the only specialist hospital in London does not have a professor of surgical oncology but a professor of surgery, and this chair was created only during this decade. And if one analyses the professors in London teaching hospitals there is only one whose major interest in research and clinical commitment is surgical oncology, though there are a number outside London.

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What is surgical oncology?

One must address two questions before debating the art or lack of it in surgical oncology in Britain. Firstly, what is a surgical oncologist? Secondly, is surgical oncology a necessary supraspecialty in surgery? A surgical oncologist should be a highly trained general surgeon interested in the treatment of cancer and knowledgeable in current techniques and treatments in radiotherapy, chemotherapy, and immunotherapy. He or she must be concerned with prevention of, and research into, cancer. The approach to the patient with cancer should be a "combined" one so that all modalities of treatment and their combinations can be discussed from the outset and the proposed treatment agreed from the start. This means, too, that should further treatment be necessary at a later stage the patient already knows and has rapport with the other specialists. I believe the surgical oncologist should and must be the "leader" of this team as he or she will either have made the diagnosis already or need to make it by providing material for histological proof of the disease. The patient too must have one person with whom he or she can

identify at the beginning, though it must be emphasised that all members of this team of experts are equal.

So, why shouldn't a general surgeon do just that and once the diagnosis is confirmed, refer the patient to a radiotherapist or medical oncologist? The main reasons are two. Firstly, when a patient is referred for an opinion many specialists then feel they should treat the patient (that is why the patient has been sent). When the patient is seen in a combined clinic this does not occur. Secondly, the treatment of cancer is changing rapidly. It is improbable that a busy general surgeon can keep abreast of specific immunotherapy, stem cell assays in chemotherapy treatment, the use of monoclonal antibodies as an investigatory tool and even possibly for treatment, the place of interstitial radiotherapy, intraoperative external beam, isolated perfusion, and the role of localised continuous infusion chemotherapy.

Will surgical oncology erode general surgery?

It has been stated that the evolution of the surgical oncologist will erode general surgery. Anxiety is widespread that patient care will be further partitioned. Several observations by Dr De Cosse argue against the usefulness of these anxieties.[1] Firstly, the growth of knowledge and complexity will continue and cannot be ignored. Secondly, no one can master all of modern general surgery; the "renaissance surgeon" has not existed for some time (in large centres of the advanced world). Thirdly, it is good for the surgeon's intellectual and professional satisfaction to have within general surgery an area of concentration that he can master and to which he can contribute, and, more importantly, it is good for the public. Finally, all specialist training programmes must insist on an educational base of sound and rigorous training in general surgery.

If these statements are generally valid it follows that at some level of cognitive and technological complexity, perceived need, and numbers of interested surgeons and training programmes, our patients will be served by recognition of surgical oncology.

It is unlikely that a hospital will have more than one designated surgical oncologist in the foreseeable future unless it be a specialist hospital or a hospital with a specialised unit.[2] This solitary surgical oncologist cannot possibly treat all patients with breast, stomach, colorectal, pancreatic, and other solid tumours as well as those with the rarer malignancies. Indeed, as mentioned, the general surgeons might have some reservations should such a new scheme be proposed, and Wellwood has pointed out[2] that we must look to them to continue to provide much of the specialist surgical oncology service in the immediate future. So what is the present role of the designated surgical oncologist?

Role of the surgical oncologist

The rarer skin and soft tissue tumours should be referred to the surgical oncologist, and he or she should develop an interest in one type of more common cancer—for example, gastrointestinal or breast cancer. The treatment of more advanced disease should be left to the surgical oncologist together with the clinical oncology team and they should act as a second or third referral centre. The oncologist should be responsible for the undergraduate teaching of surgical oncology, for setting up postgraduate training programmes, and for stimulating research into cancer by surgeons in training.

Training

I believe that undergraduate formal lectures on cancer related topics should be carried out as discussions or seminars, with the consultants from the clinical oncology team all taking part. This has worked well during the past few years at St Mary's Hospital Medical School. A postgraduate training programme in surgical oncology should start one year after the FRCS examination has been passed. A young surgeon then ought to have a busy year consolidating the theoretical knowledge and becoming an accomplished practical surgeon. If surgical oncology has been chosen he or she should spend the next year in laboratory research but during this year should attend one clinic of his or her choice—for example, melanoma, breast, colorectal—and thus have a clinical role as well.

After this research year a period of attachment to various specialty services should be undertaken, each period lasting two or three months—for example, radiotherapy, immunology, medical oncology, parenteral nutrition service. During this time he or she will have to attend structured series of lectures on epidemiology, biostatistics, the biology of cancer, the pharmacology of cancer, the psychosocial aspects, radiology, and cytology. Also during this year, the research work can be completed and written up for presentation and, hopefully, a thesis. Senior registrarship should then start, and during this four year period one year should be spent abroad in a centre of surgical oncology, one year must be spent in a busy district general hospital, and two years should be spent at a teaching centre or cancer centre, with one year in gastric or colorectal surgery and the next with a surgical oncologist.

This programme would take 10 to 11 years after qualification, which is a realistic training period for a specialist surgeon in Britain.

Let us hope we can start training programmes for aspiring surgical oncologists so that even if we do not catch up with our American colleagues this decade, at least there would be a change in the next one.

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Is it possible for a patient to have a myocardial infarction and not show any abnormality in the blood cardiac enzyme activities in the next 96 hours?

If there is myocardial necrosis a rise in the cardiac enzyme activities should be seen within 96 hours of the event. This assumes, however, that blood samples are measured sufficiently often so as not to miss the rise. Very occasionally confusion may occur because there may be a rise in cardiac enzyme activities but the actual value never exceeds the normal limit of the laboratory. The most common cause of myocardial infarction occurring without subsequent rise in the cardiac enzyme activities is probably the incorrect timing of the onset of the event. Timing may often be extremely difficult, even in patients who give a clear cut history. Many patients may have prolonged episodes of chest pain at rest and of increasing severity even for a week before admission and then being exactly sure of when the infarction occurred will be no more than educated guess work.—KIM FOX, consultant cardiologist, London.

Does the use of a sheath at intercourse lessen the risk of acquiring autoimmune deficiency syndrome?

The sheath or condom provides a mechanical barrier to the spread of infections due to bacteria, viruses, and other agents responsible for sexually transmitted diseases. The cause of acquired immune deficiency syndrome (AIDS) is completely unknown and it is therefore impossible to say whether the use of a sheath would lessen the risk of acquiring it. Most sufferers are homosexual men and as they dislike using a sheath compliance would be poor. Until the cause is discovered and some treatment is available homosexual men are recommended to avoid multiple sex partners and change of partner. They should report to their doctor or to a clinic if they have symptoms that might be due to this syndrome or if any of their former sex partners develop AIDS.—R D CATTERALL, consultant physician in genitourinary medicine, London.